TennCare CHOICES in Long Term Care

Nursing Facility Referral Form

Date of referral: ____/____/_____
(Month/ day/ year)

Name of referred resident:

Last_____ First_____ MI____

DOB_____/_____/_____ Health Plan Member ID _____

Resident Representative/Designee/Power of Attorney:

Last_____ First_____

Phone (_____) _____-_____ Relationship to resident_____

Comments: _____

Referred by:

Nursing Facility NF/SNF Provider #

_____ _____

City: _____ State: _____

(_____)_____-_____ _____
Phone Contact Name

Please check appropriate box below and fax referral to:

If resident **is** currently eligible for Medicaid:

☐ AmeriChoice **1-888-582-1963**
☐ AMERIGROUP **1-888-762-3203**
☐ BlueCare/TennCare Select **1-615-565-1993**

If resident is **not** currently eligible for Medicaid:

☐ First TN AAAD…… 1-423-926-8291
☐ South Central TN AAAD…….... 1-931-380-1493
☐ East TN AAAD…… 1-865-251-0076
☐ Northwest TN AAAD……... 1-731-587-6744
☐ Southeast TN AAAD…….... 1-423-648-9274
☐ Southwest TN AAAD……... 1-731-668-6438
☐ Upper Cumberland AAAD…….... 1-931-432-8112
☐ Aging Commission of the Mid-South AAAD…… 1-901-327-0931
☐ Greater Nashville AAAD …… 1-615-862-8876